



**BOARD OF BEHAVIORAL SCIENCES**  
 400 R STREET, SUITE 3150, SACRAMENTO, CA 95814  
 TELEPHONE: (916) 445-4933 TDD (916) 322-1700  
 WEBSITE ADDRESS: <http://www.bbs.ca.gov>



## CLINICAL SOCIAL WORKER EXPERIENCE VERIFICATION

Use a separate form for each person verifying hours of supervised experience in a clinical setting for licensure as a clinical social worker and for each employment setting. **No erasures or corrections may be made. If any error has been made, complete a new form. Make certain that the form is complete and correct.** Experience verification forms are to be submitted with the application for licensure.

**APPLICANT:** Complete Section I **SUPERVISOR:** Complete Section II

### I. APPLICANT: (Please type or print clearly in ink.)

1. Name: _____				
Last	First	Middle		
Address: * _____				
Number and Street	City	State	Zip Code	
Business Telephone: (____) _____		Residence Telephone: (____) _____		
2. BBS File Number: _____;				
Associate Number: _____			Date Issue: _____	

### II. LICENSED SUPERVISOR: (Please type or print clearly in ink.)

1. Name of Applicant's Employer: _____ Telephone: (____) _____	
<i>(Employment means the gaining of hours of experience in an allowable work setting as an employee or as a volunteer)</i>	
Address: _____	
Number and Street	City State Zip Code
2. Employment Setting:	
a. Private Practice . . . . . <input type="checkbox"/> b. Governmental Entity . . . . . <input type="checkbox"/> c. Nonprofit and Charitable Corporation . . . . . <input type="checkbox"/> d. School, College, or University . . . . . <input type="checkbox"/> e. Licensed Health Facility . . . . . <input type="checkbox"/> f. Other . . . . . <input type="checkbox"/>	
3. Dates the applicant was employed: From _____ to _____	
mo. day yr.	mo. day yr.
4. Were you, the supervisor, and the applicant both working within the same employment setting where the experience hours were obtained? . . . . . Yes <input type="checkbox"/> No <input type="checkbox"/>	
If No, please explain: _____	
5. As the supervisor I provided supervision during this time in the above employment setting on a:	
<input type="checkbox"/> Self employed basis in a private practice. <input type="checkbox"/> Paid basis . . . . . Indicate by whom you were paid: _____ <input type="checkbox"/> Voluntary basis . . . . . Attach the original written agreement between you and the applicant's employer required by Business and Professions Code, Section 4996.20(d).	

**\*The address you enter on this application will become public information. If you do not want your residence address available to the public, please provide your mailing address.**

II. LICENSED SUPERVISOR: *Continued*)

<b>Applicant's Name:</b> _____ <b>BBS File Number:</b> _____			
<b>6. Was the applicant receiving pay during this time for the employment?</b> ..... Yes <input type="checkbox"/> No <input type="checkbox"/> ♦ If Yes, attach a copy of the applicant's W-2 statement for each year experience is claimed. For the current year in which a W-2 has not been issued submit a copy of current paystub.  ♦ If No, attach a copy of agreement regarding the applicant's employment status. If no agreement was signed have the employer provide a statement indicating the applicant was a volunteer during the period for which he or she is claiming experience.			
<b>7. TOTAL NUMBER OF HOURS OF EXPERIENCE:</b>		Total: _____	
a. Total number of individual supervision hours:		a. _____	
b. Total number of group supervision hours:		b. _____	
c. Total number of hours worked per week:		c. _____	
d. Total number of weeks worked:		d. _____	
<b>8. Dates the applicant was under your supervision:</b> From _____ to _____ <div style="text-align: center; font-size: small;">mo.   day   yr.                      mo.   day   yr.</div>			
<b>9. Applicant's duties:</b> _____ _____ _____ _____ _____			
<b>10. SUPERVISOR:</b> a. My license was <input type="checkbox"/> was not <input type="checkbox"/> current during the dates listed on this form. <i>NOTE: Hours of experience gained while your license was lapsed cannot be accepted. Disciplinary action may be taken against your license if you practiced without a valid, active license.</i> b. My license was <input type="checkbox"/> was not <input type="checkbox"/> revoked, under suspension or probation during the dates listed on this form. c. If M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? ..... Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, give date Board Certified: _____  Address: _____ <div style="text-align: center; font-size: small;">Number and Street                                      City                                      State                                      Zip Code</div> Daytime Telephone Number: ( _____ ) _____  <div style="text-align: center; font-size: small;">_____ Type of License                      License Number                      State of License                      Date Originally Licensed</div> <i>I declare under penalty of perjury under the laws of the State of California that the information submitted on and with this form is true and correct.</i>  <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 20px;"><span>_____ Date</span><span>_____ Print Name</span><span>_____ Supervisor's Signature and Title</span></div>			